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Department of Health Services

DIVISION OF LONG TERM CARE

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Date: January 27, 2012

To: Agency Fiscal Contacts

From: Sylvia Fredericks, DLTC/Bureau of Financial Management

Re: CY2011 Reconciliation Packet for the Year End Close Out (CLTS)

This document serves as the reconciliation packet for CLTS for calendar year 2011.

Please share the forms with the appropriate individuals. Only **one** hard copy of the complete packet will be sent through the US Mail to the agency **fiscal contacts**.

All completed packets, including additional information as requested, are due back to the program designee by **March 23, 2012**. A packet is not considered complete if any pages are missing. If the information requested is not applicable to the agency, please mark "N/A" prominently on the page. Please mail or email the documents back. Email is preferred. If emailing, please type your name on the signature line and indicate in the text of the email that you approved the documents. Program designees are listed below.

The contact information for the above Program Designee is below:

Division of Long Term Care
Bureau of Financial Management
P.O. Box 7851
Madison, WI 53707
Attn: Sylvia Fredericks

(608) 267-3659 (phone)
Sylvia.Fredericks@Wisconsin.gov

Agency Name:

CY2011 – CLTS Reconciliation Contact Information

Please fill out the below form with the contact information for the **primary** contact for the Children's Long Term Support CY2011 reconciliation.

The primary contact person should be the individual who is best able to address any questions or concerns related to these forms. All communications will begin with this person.

Primary Contact

Name	
Phone Number	
Email Address	
Fax Number	
Mailing Address	

The secondary contact person should be the individual who is best able to address any questions or concerns related to these forms if the primary contact is unavailable. This person will only be contacted in the event that the primary contact is unavailable AND will be copied on the final reconciliation communication.

Secondary Contact

Name	
Phone Number	
Email Address	
Fax Number	
Mailing Address	

Reponses on this form are used to generate the CLTS fiscal contact list for CY2012, which is used for haring information and mailing contract update letters. If the contact person for 2012 is someone other than the two contacts listed, please let Sylvia Fredericks know when you submit these forms.

Agency Name:

Administrative Cost Claim Form – CLTS Other

A maximum of 7% administration is allowed for each waiver (DD, MH, and PD). Variances from 7% can be approved in special circumstances. A variance request form is included in this packet. All claims for administrative costs must be supported by written evidence by the agency and not billed to another funding source.

Please fill out the table below, indicating your agency's total anticipated service expenditures, total administrative claim, and the combined total for the agency's total claim for CY2011. Please indicate in the final column if you anticipate that any part of the service expenditures will not be paid until after **March 25, 2012**.

CLTS Other	Total Service Expenditures		Admin Claim	Total Claim (Service + Admin)	Paid after 3/25/12?
CLTS DD (CARS Profile 422/803)	**HSRS**	**TPA**			
State Match					
Local Match: COP					
Local Match: FSP					
Local Match: Comm. Aids/Tax Levy					
Total CLTS DD Other					
CLTS MH (CARS Profile 432/809)	**HSRS**	**TPA**			
State Match					
Local Match: COP					
Local Match: FSP					
Local Match: Comm. Aids/Tax Levy					
Total CLTS MH Other					
CLTS PD (CARS Profile 442/815)	**HSRS**	**TPA**			
State Match					
Local Match: COP					
Local Match: FSP					
Local Match: Comm. Aids/Tax Levy					
Total CLTS PD Other					

Agency Name:

Administrative Cost Claim Form – CLTS Autism

A maximum of 7% administration is allowed for each waiver (DD, MH, and PD). Variances from 7% can be approved in special circumstances. A variance request form is included in this packet. All claims for administrative costs must be supported by written evidence by the agency and not billed to another funding source.

Please fill out the table below, indicating your agency's total anticipated service expenditures, total administrative claim, and the combined total for the agency's total claim for CY2011. Please indicate in the final column if you anticipate that any part of the service expenditures will not be paid until after **March 25, 2012**.

CLTS Autism	Total Service Expenditures		Admin Claim	Total Claim (Service + Admin)	Paid after 3/25/12?
CLTS DD (CARS Profile 420/800)	**HSRS**	**TPA**			
State Match					
Local Match*					
Total CLTS DD Autism					
CLTS MH (CARS Profile 430/806)	**HSRS**	**TPA**			
State Match					
Local Match					
Total CLTS MH Autism					
CLTS PD (CARS Profile 440/812)	**HSRS**	**TPA**			
State Match					
Local Match					
Total CLTS PD Autism					

Please answer each question below. This questionnaire is used to support the administrative cost claims.

1. **How much of the total CLTS administrative claims is attributable to staff?** Your response should be a dollar amount.

2. **How much of the total CLTS administrative claims is attributable to overhead costs?** Your response should be a dollar amount.

3. Some agencies may include other expenses in their administrative claim. **If your agency is including other expenses, please list the dollar amount and what expense is claimed.**

4. Some CLTS expenses are claimed by agencies in their case management rate**. Were expenses claimed in your case management rate excluded from the administrative claim?**

Agency Name:

Ineligible Setting Report

Please report the following information for each participant who was in an ineligible setting **after the agency's transition to the TPA**. This should include all participants who would have been listed under SPC 503 – Inpatient Stay in HSRS.

Agency Name	Participant MCI	Ineligible Start Date	Ineligible End Date

I understand and affirm by my signature that the information reported in this document (Pages 2-5) is true and correct to the best of my knowledge.

Signature _____ **Date** _____

Name and Title _____